NREPP SAMHSA's National Registry of Evidence-based Programs and Practices

Evidence Summary
Adult Drug Courts

What are Adult Drug Courts?

Adult drug courts (ADCs) utilize a public health approach to problem-solving that helps court-involved individuals with substance use disorders enter into long-term recovery. Services are coordinated for ADC participants by a case management team, which involves the judiciary, prosecution, defense counsel, probation, law enforcement, mental health, social service, and treatment communities working together to help the drug court client through the recovery process.

The Bureau of Justice Assistance (BJA) outlined 10 key components of adult drug courts in 1997, after several years of implementation experience in the United States. Following the release of the National Institute of Justice's (NIJ's) multisite adult drug court evaluation in 2011, NIJ and BJA identified seven program design features of adult drug courts. The 10 key components (BJA, 1997) and seven program design features (NIJ & BJA, 2011) both emphasize thorough screening and assessment, identification of the target population, administration of procedural and distributive justice, standards for judicial interaction, rigorous monitoring, and the provision of treatment and other services.

Those individuals who meet assessment and eligibility criteria engage in a multiphase program, which involves frequent drug testing, biweekly or weekly meetings in court, and coordinated case management with graduated sanctions and incentives. Compared with the 1997 10 key components, one of the distinguishing features of the seven program design features is the emphasis on relapse prevention, aftercare planning, and community reintegration strategies throughout the individual's participation in the ADC program (NIJ & BJA, 2011). Adult drug court programs average about 12 to 15 months in length, and graduates typically receive a legal advantage such as a case dismissal or reduction in sentence (Rempel et al., 2012). Nationally, approximately half of ADC participants graduate or complete their treatment programs (Brown, 2010).

Implementation Context

Practices in adult drug courts vary substantially (Carey et al., 2012; Mitchell et al., 2012b; Rossman et al., 2011). Typically, law enforcement officials are involved in screening court-involved individuals with substance use disorders for drug court participation. Most programs consider only nonviolent court-involved individuals to be eligible for participation (Mitchell et al., 2012b). Drawing from research by Bonta and Andrews (2007), NIJ recommends the Risk-Need-Responsivity Model of screening and assessment in order to match the treatment program intensity to the individual's risk of recidivism. Programs target treatable criminogenic behaviors or needs and provide cognitive–behavioral therapy aligned with the individual's learning style, motivation, and attributes (NIJ & BJA, 2011).

Once individuals pass the screening criteria, they receive an offer to participate in drug court and learn how charges against them will be reduced or dropped after successful program completion. Those who agree to participate then become ADC clients. ADCs offer two main approaches to court processing: 1) a "pre-plea" method, in which clients waive their right to a speedy trial and enter drug court; and 2) a "post-plea" method, in which clients who are already convicted, but not yet sentenced, are admitted to drug court. Typically, ADC programs consist of several phases, which vary in intensity and end in a graduation ceremony (Mitchell et al., 2012b). For example, Phase I may involve clinical evaluation, initial treatment, and drug testing. Phase II provides more intensive substance use treatment, family treatment, and support services. Phase III continues to extend and intensify treatment, drug testing, and support services as needed. Finally, during Phase IV, the focus is on establishing a plan for continuation of care and reducing drug testing and court appearances. On average, ADC participants require about 6 to 10 hours of counseling during the first phase (Landenberger & Lipsey, 2005) and about 200 hours of counseling throughout the program (Bourgon & Armstrong, 2005; Sperber et al., 2013).

Origins and Population Served

ADCs began in the 1980s, as a result of criticisms of ineffective law enforcement and correctional policies, the rapid influx of individuals with substance use disorders who were entering the criminal justice system (Sevigny et al., 2013), and a growing recognition of the need for appropriate treatment of substance use disorders. Over the past 30 years, Congress passed a number of laws requiring stricter sentencing that had the corollary effect of increasing prison terms for individuals with substance use disorders (Pew Charitable Trusts, 2015). For example, in 1984, Congress passed the Sentencing Reform Act, which eliminated federal parole and required all inmates to serve 85% of their sentences (Pew Charitable Trusts, 2015). Among individuals sentenced between 1984-1990, Meierhoefer (1992) found an increase in the length of prison terms (from an average of 2 years in 1984 to 3 years in 1990), as well as a rise in the proportion of court-involved persons in using drugs (from 16% in 1984 to 27% in 1990). Simultaneously, treatment for substance use disorders evolved to recognize that substance use disorders are chronic medical conditions that require individually-tailored treatments (Kleber et al., 2006; McClellan et al., 2010)

The first adult drug court began in 1989 in Miami-Dade County, Florida. Among the more than 3,000 drug courts operating in the United States, half of them are adult drug courts (Marlowe et al., 2016; National Drug Court Resource Center, 2015). Drug courts operate in all 50 states and

the District of Columbia, Northern Mariana Islands, Puerto Rico, and Guam (Franco, 2010). Bhati and Roman (2010) estimated the annual enrollment in U.S. adult drug courts to be about 55,000 court-involved individuals.

The founding principles of adult drug courts are based on the concept of therapeutic jurisprudence, which values the promotion of therapeutic outcomes for court-involved individuals as well as proper administration of laws and legal procedures to administer justice (Rottman & Casey, 1999). In contrast to a traditional, administrative court process that prioritizes adjudication and the role of the judge in resolving a legal outcome, adult drug courts follow a collaborative process. The judge coaches a treatment team to work on alternative legal resolutions in favor of therapeutic results. Geared primarily toward court-involved adults in need of substance use treatment, ADCs are not intended to serve adults with co-occurring mental health disorders. However, ADCs have served as a catalyst for the development of other specialized problem-solving courts such as mental health courts, which do serve adults with co-occurring substance use and mental health disorders.

According to the National Survey on Drug Use and Health (SAMHSA, 2013), 35 percent of the estimated 4.5 million adults aged 18 or older, who were on probation during the previous year, misused drugs or alcohol (most recent month prior to survey administration). Among the 1.7 million American adults on parole, more than one third (34.3 percent) misused drugs or alcohol. Among American adults aged 18 or older, not on probation or parole, the rate of misusing drugs or alcohol is only about 8 percent (SAMHSA, 2013). Even though the strong association between crime and substance use has been well-documented, most people who need treatment do not receive it (Sung et al., 2004).

Best Practice Standards

For 2 decades, the National Association of Drug Court Professionals (NADCP) has worked with governmental agencies at federal, local, and state levels to guide improvements to policies and practices used in adult drug courts. After 6 years of work by scholars and expert practitioners, NADCP published the most recent set of Adult Drug Court Best Practice Standards, in 2013 (Volume I) and 2015 (Volume II). Ten standards reinforce comprehensive service delivery by a multidisciplinary team, supported by ongoing accountability, assessment, and evaluation (NADCP, 2013, 2015). Among 24 states that responded to a 2015 NADCP survey, 20 of them had adopted Volume I of the drug court standards by the time Volume II was released. Adoption and implementation of the NADCP standards has continued to spread.

Table 1. Summary of Adult Drug Court Best Practice Standards	
1.	Use empirical evidence to guide decisions of drug court eligibility and exclusion criteria, as well as evidence-based assessment tools and procedures to determine which court-involved individuals should be admitted to drug court.
2.	Provide equal access to drug court participation and systemic support for success to individuals who have historically experienced sustained discrimination or reduced social opportunities due to their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status.
3.	Ensure that drug court judges are knowledgeable about current drug court laws and best practices, as well as regularly participate in team meetings and support the contributions of all team members to serve drug court participants' success.

4.	Provide incentives and consequences that are predictable, fair, consistent, and use evidence-based principles of effective behavior modification.
5.	Implement evidence-based interventions documented in treatment manuals, based on standardized assessment of individuals' treatment needs.
6.	Provide drug court participants with complementary treatment and social services for conditions that co-occur with substance use, which tend to interfere with treatment compliance, increase criminal recidivism, or diminish treatment gains.
7.	Implement accurate, timely, and comprehensive assessment of unauthorized substance use throughout individuals' participation in drug court programs.
8.	Engage a dedicated multidisciplinary team of professionals to manage day-to-day drug court operations, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment, and supervision services.
9.	Serve as many eligible individuals as practicable, while maintaining continuous fidelity to best practice standards.
10.	Routinely monitor the drug court's adherence to best practice standards and employ scientifically valid and reliable procedures to evaluate its effectiveness.

Based upon a cost-effectiveness and outcome analysis of 69 adult drug court programs and over 200 practices, Marlowe et al. (2012) further identified a set of top 10 evidence-based practices for reducing recidivism of ADC participants. Some of these practices were also highly cost effective, based upon a comparison of recidivism-related costs for participants versus comparison group members in the 2 years after drug court entry.

Table 2. Reductions in Recidivism and Cost Savings from Top Ten Evidence-Based Practices (EBPs)

Top 10 Evidence-Based Practices (EBPs) and Their Associated Cost Savings	% Greater Reduction in Recidivism, Compared with Program Without This EBP	% Higher Cost Savings, Compared with Program Without This EBP
1. Maintain caseloads of less than 125 active participants.	5% higher recidivism reduction	Not significant
2. Require participants to be drug-free for at least 90 days in order to graduate from the ADC program.	164% greater recidivism reduction	Not significant
3. Provide participants with at least 3 minutes of time with the judge during court hearings.	153% greater recidivism reduction	Not significant
4. Engage in frequent email communication among treatment providers and court officials to maintain effective and immediate sanctions and rewards.	119% greater recidivism reduction	Not significant
5. Require a treatment provider representative to attend drug court team meetings.	105% greater recidivism reduction	Not significant
6. Use internal review of program data to improve program performance and operations, and guide training and staff development.	105% greater recidivism reduction	131% higher cost savings

7.	Require a treatment provider representative to attend court hearings.	100% greater recidivism reduction	81% higher cost savings
8.	Serve clients with non-drug charges (e.g., theft or forgery) with co-occurring substance use.	95% greater recidivism reduction	Not significant
9.	Include a law enforcement representative in the team management meetings and court hearings.	88% greater recidivism reduction	42% higher cost savings for team meetings; 64% higher cost savings for court sessions
10.	Conduct an independent evaluation and use results to improve ADC operations.	85% greater recidivism reduction	100% higher savings

Marlowe et al. (2012) found that four of the top 10 evidence-based practices also produced substantial cost savings, as shown in Table 2 above. Six additional practices produced substantial cost savings on recidivism-related costs of rearrests, new court cases, probation and parole time served, and incarceration in jail and prison. Other cost-saving practices include 1) imposing immediate sanctions after noncompliant behavior, 2) inclusion of the defense attorney in regular team meetings, 3) requiring participants to have a job or be in school, 4) providing team members with printed copies of guidelines for sanctions, 5) making drug test results available in 48 hours or less, and 6) collecting drug tests at least twice per week in the first phase.

Additional research has highlighted several other practices associated with substantial increases in ADC participant outcomes. Based on a 5-year longitudinal study of 23 adult drug courts across the United States, Rossman et al. (2011) found that the most effective drug courts held judicial status hearings at least twice per month, held weekly clinical case-management sessions, conducted urine drug testing at least twice a week, provided at least 35 days of formal substance use–treatment services, and provided increased affirmation, positive encouragement, and respectful interaction. In an assessment of 96 effectiveness studies of adult drug courts, Gutierrez and Bourgon (2012) discovered that certain practices typically resulted in poor or harmful outcomes. These researchers found that multiweek jail sanctions for positive drug or alcohol tests, standardized treatment regimens for all participants, and denial of needed medications had negative effects on desired outcomes.

Evidence of Overall Effectiveness

The results of effectiveness studies of adult drug courts have been synthesized in multiple meta-analyses,[1] systematic reviews, and multisite studies—the most recent of which have been produced from 2005 to 2013 (Sevigny et al., 2013; Mitchell et al., 2012a, 2012b; Carey et al., 2012; Government Accountability Office [GAO], 2011; Rossman et al., 2011; Brown, 2010; Shaffer et al. 2011, 2006; Aos et al., 2006; Latimer et al., 2006; Wilson et al. 2006; Lowenkamp et al., 2005).

[1] Meta-analysis synthesizes the average effects of an intervention through advanced statistical analysis. Meta-analysis begins with a systematic literature search, application of standardized screening and rating criteria to determine study inclusion, and scientifically averaging the effects of the intervention among the eligible studies (Lipsey & Wilson, 2001).

Among these 11 publications, about 150 effectiveness studies from 1993–2012 have been analyzed and generally show positive effects of adult drug courts.

Recidivism

Based on this evidence, adult drug courts reduce 2-year rearrest rates by an average of 8 percent to 14 percent (Marlowe et al., 2016). More effective adult drug courts have reduced recidivism by 35 percent to 80 percent (Marlowe et al., 2016 citing Carey et al., 2012; Lowenkamp et al., 2005; Shaffer, 2011, 2006). Most studies assess recidivism 1 or 2 years after program participation (e.g., GAO, 2011). However, some meta-analyses (GAO, 2011; Mitchell et al., 2012a, 2012b) and some randomized controlled trials (Gottfredson et al., 2005, 2006; Turner et al., 1999) have shown that the positive effects of ADCs on recidivism may last for 3 years after program. In fact, the positive effects of reduced recidivism from drug court participation may persist long after the program ends. In a long-term, quasi-experimental analysis of more than 11,000 participants in the second oldest U.S. drug court (Multnomah County, Oregon), Finigan et al. (2007) found that positive effects on recidivism lasted up to 14 years.

Table 3. Summary of Meta-Analytic Findings on the Effects of Adult Drug Courts on Reduced Criminal Recidivism

Meta-analysis study authors	Number of drug courts	Average reduction in criminal recidivism rate
Aos et al., 2006	57	8%
Carey et al., 2012	69	32%
GAO, 2011	32	6%–26%
Latimer et al., 2006	66	14%
Lowenkamp et al., 2005	22	8%
Mitchell et al., 2012a; 2012b	92	12%
Rossman et al., 2011	23	10%
Shaffer, 2006, 2011	76	9%
Wilson et al., 2006	55	14%–26%

Incarceration

Sevigny, Fuleihan, and Ferdik (2013) investigated the effects of ADCs on incarceration outcomes in a meta-analysis of 19 studies. They found that drug courts "significantly reduced the incidence of incarceration from a base rate of 50% to roughly 42% for jail, 38% for prison, and 32% for overall incarceration" (p. 423). Compared with other community-based interventions, however, while drug courts reduced incarceration rates, they did not reduce incarceration time. Sevigny et al. (2013) reported that ADC participants who do not graduate still have lengthy incarceration time with increased monitoring and confinement for noncompliance, which may exceed sentences of traditionally supervised court-involved individuals.

Other Outcomes

In addition to the positive effects on recidivism and incarceration rates, adult drug courts have also demonstrated benefits on a range of other outcomes, including reductions in drug and alcohol misuse and improvements in socioeconomic outcomes (i.e., employment and education), family relationships, and access to needed financial and social services (Green & Rempel, 2012; Rossman et al., 2011). Based upon a quasi-experimental analysis of the effects of 23 ADCs, Rossman et al. (2011) found that some small positive effects were retained up to 18

months after program completion. These included less family conflict, reduced drug and alcohol misuse, and less need for financial and social services. However, NIJ's Multisite Adult Drug Court Evaluation (MADCE) did not report any benefits from ADCs on improved mental health or reduced homelessness 18 months after program completion (Rossman et al., 2011). This multisite evaluation found that ADCs were less effective for substance use outcomes for individuals with co-occurring mental health disorders; 39 percent of the sample indicated depression or personality disorder.

As discussed earlier, not all drug courts are equally effective. Lowenkamp, Latessa, and Smith (2005) assessed the influence of how well courts adhere to treatment objectives of ADCs and recidivism rates. Among 38 ADC programs, the authors found that the comparison groups for 15 of the 38 programs (39 percent) actually had recidivism rates that were about 4 percentage points lower than those of ADC participant groups. Lowenkamp et al. (2005) found that drug courts with stronger implementation and effectiveness produced better results in reduced recidivism (i.e., new offenses, technical violations, and return to prison). Other meta-analyses have also reported greater effects from programs effectively implementing evidence-based practices (Carey et al., 2012; Marlowe et al., 2012; Shaffer, 2006).

Effectiveness of Population-Specific Treatments in Adult Drug Courts

Some researchers have investigated the effectiveness of gender-responsive (GR) drug court programs for women (e.g., there are only women in the program and on staff, and GR treatment curricula is used), compared with mixed-gender traditional programs (Messina et al., 2012). While few experimental studies have been conducted on GR drug-court treatment programs, the evidence reports inconsistent positive effects of these programs on outcomes such as alcohol and drug use, psychiatric symptoms, and criminal behavior. In a randomized controlled trial of four GR drug court programs, Messina et al. (2012) reported better in-treatment performance for women in the GR condition (e.g., fewer jail time sanctions), although there were no statistically significant differences in drug use reduction, improved psychological functioning, or reductions in arrests.

Few studies have been conducted on the effectiveness of interventions designed to improve treatment access and results for racial and ethnic minorities (NADCP, 2013). However, Vito and Tewksbury (1998) found that experienced African American treatment providers working with African American court-involved adults can improve outcomes for this population by working to combat negative racial stereotypes. The effectiveness of culturally responsive treatment for racial and ethnic minorities depends on the training and skills of providers delivering services (Castro et al., 2010). Adult drug courts have experimented with how to better serve specialized populations and learn from the program's results and implementation. For example, NADCP (2013) reported that a controlled experimental study was examining a holistic intervention called HEAT (habilitation, empowerment, and accountability therapy), which was designed to serve 18–29-year-old African American men.

Cost-Effectiveness of Adult Drug Courts

Several recent studies and meta-analyses have demonstrated ADCs to be highly cost effective (e.g., Drake, 2012; GAO, 2011; Mayfield et al., 2013; Rossman et al., 2011). Cost-effectiveness studies such as these have reported a 200 percent or 400 percent return on investment; for every

dollar spent, an average of $2 to $4 is saved in future court and related costs (Marlowe et al., 2016). On average, adult drug courts produced approximately $3,000 to $22,000 of net economic savings per participant (Marlowe et al., 2016). However, cost estimates are not strictly comparable across studies. For example, Rossman et al. (2011) compared their cost–benefit results to nine other studies and found variance in methodological rigor and specifications, which made the cost estimates difficult to compare. In a Bayesian analysis of the cost effectiveness of adult drug courts that drew on prior experimental evidence, Downey and Roman (2010) found that benefits could be as high as $23,000 per participant (1 percent of estimated population). These authors further estimated that the mean marginal cost of drug court participation was about $10,190 more than would be spent without the program, with a 14 percent chance that benefits would exceed the costs.

Table 4. Summary of Several Cost-Effectiveness Studies of Adult Drug Courts

Study authors	Study sample	Return on investment in crime-related costs (for every dollar spent)	Per-participant savings (in year of analysis)	Source
Bhati et al., 2008	95,415 eligible adults	$2.21	$6,542	Table 4.4, p. 55
Drake, 2012	45 adult drug courts	$1.77	$3,208	Exhibit 1, p. 6
Drake et al., 2009	Not reported	Not reported	$8,514	Table 1, p. 185
Lee et al., 2012	Not reported	$3.69	$11,265	Exhibit 1, p. 4
Mayfield et al., 2013	3,342 adults	$4.02	$21,987	Figure 11, p. 7
Rossman et al., 2011	23 adult drug courts	$2.00	$6,208	p. 257

Research Quality and Future Research Directions

The level of rigor varies among effectiveness evaluations of adult drug courts, although several randomized controlled trials have been conducted (e.g., Deschenes et al., 1995; Gottfredson, Najaka, & Kearley, 2003; Gottfredson et al., 2005, 2006; Harrell, Cavanaugh, & Roman, 2000; Jones, 2013; NPC Research, 2015; Turner, Greenwood, Fain, & Deschenes, 1999). In an analysis of differential effect sizes reported relative to the methodological rigor of studies, however, Mitchell et al. (2012a, 2012b) concluded that while more rigorously conducted studies produced lower effect sizes for reduced criminal and drug-use recidivism from ADCs, the difference was not statistically significant.

As part of their research informing best practice standards, NADCP (2013) cited evidence regarding racial and ethnic minorities' disproportionate access to, retention in, and treatment by adult drug courts. Additionally, researchers have reported lesser quality treatment and harsher sanctions and sentencing for racial and ethnic minorities in adult drug courts (NADCP, 2013). According to NADCP (2013), available evidence estimates that African American and Latino court-involved adults are underrepresented by 3–7 percent in drug court programs. Furthermore, African American and Latino participants have significantly lower rates of

graduation from drug court programs (estimated at 25–40 percent), compared with non-Hispanic whites.

NADCP recommends that ADC programs assess how eligibility criteria and screening practices may disproportionately preclude access to drug court participation for racial and ethnic minorities. Independent evaluations of ADC programs may also be instructive in understanding effective strategies for closing gaps in treatment outcomes and investigating ways to support underserved groups excessively burdened by disparities in access to quality schools and employment opportunities. As adult drug courts work to implement the best practice standards, including adoption of culturally responsive practices that work to close treatment gaps for underserved populations, future research would provide insight into the effectiveness of new practices and their robust implementation.

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